Developed countries' National Medical Associations, the Right to Health and the Millennium Development Goals in developing countries

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Introduction

What is the "the role and (potential) work of National Medical Associations ("NMAs") with their own Governments and developing country NMAs with respect to the Right to Health and the MDGs"?

We start from the position that developed countries have a duty under international law not only to realise the rights recognised under international human rights law, including the right to the highest attainable standards of health ("right to health") in their own countries but also to assist and cooperate with developing countries in the promotion of those rights.[1] Though the precise contours and content of such duty are still not very clear, there is a growing consensus in the literature that this duty exists.[2] Moreover, all States members of the United Nations agreed, in the Millennium Declaration of 2000, to pursue, through a partnership for development, a set of eight specific goals (the millennium development goals "MDGs"), four of which are directly related to health.

It is clear that those duties fall primarily on States. But civil society has an important role to play not only in making sure that the State complies with its duties, as it has become clear in all issues involving human rights, but also directly through projects related to the MDGs.[3] In the specific field of health, the right to health and the health related development millennium goals ("MDGs"), organisations of health professionals including their national associations are in a prominent place to exert this role incumbent on civil society.

In order to find out what NMAs should and can do, we have looked for examples of initiatives pursued by NMAs (or other medical organisations) which are somehow related, directly or indirectly, explicitly or not, to the right to health and MDGs. We have also done a brief literature review on the moral grounds and practical motives for such work. Given the limits of time and resources at our disposal, we have not produced an in depth study of the moral and practical foundations of the NMAs role. Nor is the list of initiatives we present as examples of good practice comprehensive. We could also not visit the initiatives and interview the people affected to establish if they actually work in practice. Within the limits of a desk review such as this, we have rather tried to highlight a few examples of activities we managed to retrieve which, at first sight, seem to be going in the right direction and could perhaps be emulated by other NMAs.

The research methods used were: i. searches in the internet, particularly in the websites of NMAs (when available and in accessible language). The site of the World Medical Association provided a point of departure for the webpages of its members; ii. Literature search in databases and library catalogues; iii. Personal and email interviews and consultations with experienced professionals in the field;[4] iv. Email Questionnaires to NMAs and v. phone and personal conversations with representatives of NMAs.

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[1] Ferraz and Mesquita (2006), *The right to health and the Millennium Development Goals in developing countries: A right to international assistance and cooperation?*

[2] See mentioned paper, note 1 above, and, for a good recent review of the literature, Skogly (2006).

[3] It is hard to overlook the important role played by NGOs in raising awareness, applying pressure on governments and delivering goods and services directly on issues related to human rights. A high profile example of direct civil society involvement in the achievement of health related MDGs is the Malaria Project run by the LSTMH and funded by the Bill and Melinda Gates Foundation.

[4] We are grateful for the responses of Jim Welsh, from Amnesty International, Marianne Halesgrave, from the Commonwealth Medical Trust, Dr Peter Hall, from Doctors for Human Rights, Adriaan van Es, from IFHHRO -

The paper is divided as follows. In section I we deal with the role of National Medical Associations in the field of human rights, in particular the right to health and health related MDGs. To put the question into context, we start by highlighting that NMAs around the world differ in several ways and that this has of course an impact in their role regarding human rights. We also provide a brief account of the right to health and the MDGs. We then move on to discuss the role of health professionals regarding the right to health and health-related MDGs, including its moral foundations. Here we focus mainly on their own perception of their responsibilities. In section II we look at the more practical issue of what NMAs can actually do. We start by a brief review of some seminal reports on the topic which have put forward examples of potential work for NMAs in the field of human rights in general and the right to health in particular. We then discuss the main areas of activities identified trying to illustrate each of them with examples of initiatives that seemed to us to be cases of good practice.

I
The role of National Medical Associations

Different types of NMAs

It is important to note, at the outset, what we mean by National Medical Associations (NMAs). National medical associations are set up in different ways in different countries, have different terms of reference and are able to command different levels of resources. This is certainly relevant to what role they should and can play to advance the right to health and MDGs.

There are broadly three separate, though sometimes interconnected functions that professional doctors' organizations play: (i) representation of their members in their professional interests; (ii) regulation of the practice of medicine and discipline of its practitioners, and (iii) promotion and defence of the medical science and good practice in medicine in general.

In some countries distinct organisations, respectively the doctors' trade unions, the medical council and the medical association perform these functions. In others, one organisation accumulates two or all of these functions. The British Medical Association, for instance, is a trade union and thus represents its members in their corporative interests such as pay, working conditions etc, but is also, according to its articles of association, in charge of advancing and promoting medicine. But it does not have any regulatory or disciplinary functions. Those are the domain of the General Medical Council.[5]

It is also important to bear in mind that not all countries have yet formal organisations to perform all those functions. In Ethiopia, for instance, the regulation and discipline of the profession is exclusively undertaken by the Ministry of Health, though the National Medical Association is trying to bring this role within its remit.[6] In Sudan, the Sudan

International Federation of Health and Human Rights Organisations to our consultation, all of which were highly valuable in the preparation of this paper.

[5] See *The Medical Profession and Human Rights*, BMA, 2004, p. 504. The BMA articles of association states as the associations first object *"(1) To promote the medical and allied sciences, to maintain the honour and interests of the medical profession and to promote the achievement of high quality health care."*

[6] Interview with the president of the Ethiopian Medical Association, Dr Adem Ali, on 30.6.2006.

Medical Union is chiefly a trade union and has only recently started to carry out some of the tasks typically discharged by national medical associations, such as involvement with health policy.[7]

The number of members in different medical associations and the resources they are able to command through membership fees also vary significantly. The BMA, for instance, has over 138,000 members who pay a reasonable fee for their membership. The German Medical Association represents more than 400,000 doctors. The Sudan Medical Union, by contrast, represents around 10,000 doctors, which amounts to almost all the doctors who practice in the country. 60% of the doctors trained in Sudan, around 12,000, work abroad, mostly in Saudi Arabia, UK and Ireland. With a GDP per capta of US$ 340 it is not difficult to imagine what magnitude of resources the SMU is able to command.

Given all this heterogeneity in terms of remit and resources, it is unreasonable to expect that all NMAs exert the same role (or with the same effectiveness) in promoting the right to health and the MDGs.

The right to health, MDGs and health professionals

It is important to say something briefly on the right to health and the MDGs before we look at NMAs potential role.

The Right to Health - Health has been recognised as a human right in several international and domestic legal instruments. Adopted in 1946, the Constitution of the World Health Organization recognizes the fundamental human right to health. Two years later, the Universal Declaration of Human Rights laid the foundations for the international legal framework for the right to health. Since then, the right to health has been codified in numerous legally binding international and regional human rights treaties. In the International Covenant on Economic, Social and Cultural Rights ("ICESCR"), the United Nations instrument that more than 150 countries agreed to respect, the "right to health" is formulated as a right to *"the highest attainable standard of physical and mental health"*. (art. 12)

The right to health is also enshrined in numerous national constitutions: over 100 constitutional provisions include the right to health, the right to health care, or health-related rights such as the right to a healthy environment. The Brazilian Constitution, for instance, states that "***health*** *is a right of all and a duty of the State*" (art.196). The South African Constitution recognises a right *"to have access to health care services"*. (section 27)

The right to health includes the right to health care, but it goes beyond health care to encompass safe drinking water, adequate sanitation and access to health-related information, including on sexual and reproductive health. The right includes freedoms, such as the right to be free from involuntary sterilization, as well as to be free from discrimination in health programmes and services. It also includes entitlements, such as the right to a system of health protection. The right has numerous elements, including child health, maternal health and access to essential drugs. Like other human rights, it has a particular preoccupation with the disadvantaged, the vulnerable and those living in poverty. The right requires an effective, inclusive health system of good quality.

[7] "The case of professional associations in Sudan", presentation given by Dr Elsheikh Badr, of the Sudan Medical Union, at the BMA Conference *"Improving Health in the Developing World: what can National Medical Associations do?"* held in June 30 2006.

"8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health." General Comment 14, UN Committee on Economic, Social and Cultural Rights

Although subject to progressive realization and resource availability, the right to health imposes some obligations of immediate effect, such as non-discrimination. It demands indicators and benchmarks to monitor the progressive realization of the right. The right to health also encompasses the active and informed participation of individuals and communities in health decision-making that affects them. Under international human rights law, developed States have some responsibilities towards the realization of the right to health in poor countries. Because the right to health gives rise to entitlements and obligations, it demands effective mechanisms of accountability.

The Millennium Development Goals (MDGs) - Representatives of 189 Member States, including 147 heads of State or Government, adopted the United Nations Millennium Declaration at the Millennium Summit in New York in September 2000. The Declaration sets out principles and values to govern international relations in the new century and it identifies seven areas in which national leaders make a series of specific commitments. The seven areas include development, poverty eradication and human rights.

One of the most striking features of the Goals is the prominence they give to health. Of the eight Goals, four are directly related to health:

– Reduce child mortality (Goal 4);

– Improve maternal health (Goal 5);

– Combat HIV/AIDS, malaria and other diseases (Goal 6);

– Ensure environmental sustainability (including reducing by half the proportion of people without sustainable access to safe drinking water (Goal 7).

Two other goals are closely related to health: Goal 1 (to eradicate extreme poverty and hunger), and Goal 8 (to develop a global partnership for development). Both remaining goals (achieving universal primary education and empowering women, Goals 2 and 3) have a direct impact on health. Further, at least 8 of the 16 Millennium Development Goal "targets" and 17 of the 48 "indicators" are health-related. Health is central to the Millennium Development Goals because it is central to poverty reduction and development. Good health is not just an outcome of poverty reduction and development: it is a way of achieving them.

As it is readily apparent, there is a close correspondence between the health related millennium development goals and the right to health.

Health professionals and NMAs - A great deal of health interventions needed to further the health related MDGs and the right to health alike can be devised and delivered only by those who have trained in some of the health professions. Doctors, and other health professionals, are integral for the advancement of the health related MDGs and, as a consequence, to the promotion of the right to health. Due to the nature of their profession, moreover, they are often in a position to identify right to health violations[8] and also to be part (deliberately or unwittingly) in abuses of the right to health of individuals.

Many components of the right to health are somehow dependent on, or can involve to some extent, *health professionals*. Non-consensual medical treatment and experimentation, for instance, are wrongs that by their nature can be only carried out by health professionals. History is sadly full of cases of health professionals who participated directly, were complicit or omitted in acts of torture.[9] A system of health protection, in turn, is devised and delivered mainly by health professionals. As noted in a seminal paper on health and human rights,

> *"health practitioners can – and in most cases do – have a strong positive influence on the promotion and protection of human rights within the populations they serve. Yet violations of human rights perpetrated by health professionals regularly occur. These include not only such egregious examples as physician participation in torture and other severe violations of human rights, but also actions in the provision of treatment and care. For example, when care providers make decisions concerning patient access to available prevention services, children with a chronic fatal disease or disability may be denied immunization against measles and other preventable childhood infections (UN 1998b; Savage 1998; Ward, Myers 1999). In many countries, rich and poor, patients with diabetes, carcinoma, chronic renal syndrome, mental disability, haemophilia or other severe health conditions may receive a lower standard of care than others not only with respect to the health issue in question but in general because their possibility of cure is regarded as limited (UN1992b; Crofts et al. 1997)."*[10]

As noted in the Special Rapporteur for the Right to the Highest Attainable Standards of Health, thus, *"as providers of health care services, health professionals play an indispensable role in the realization of the right to health."*[11]

It seems clear thus that health professionals are essential *instruments* in the realization of many aspects of the right to health. But what *role, moral or legal*, arise from this special relation between health professionals and the right to health?

More specifically, should they be concerned with the right to health and MDGs in developing countries and, if so, can and should they do something about it, in particular through their national medical associations?

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[8] It also shows the importance of interdisciplinary work in this field. Some health professionals are experts in public health interventions whose aim is the improvement of the health conditions of the population as a whole and therefore significantly overlap with the right to health. Public health policies, however, can inadvertently (and deliberately) violate right to health by for instance discriminating some groups or neglecting their needs. A health policy that might seem efficient from a public health perspective because it reduces significantly the burden of a certain disease might nevertheless be contrary to the right to health in that if neglects a part of the population that suffers from that disease. See, for instance, Health Inequalities: Concepts, frameworks and policy, Briefing Paper, NHS, Health Developing Agency 2004, stating that only recently the public health aim in the UK changed from simply "health gain" to "health equity". See also, on the need for human rights training and interdisciplinary efforts Gruskin and Tarantola (2000), p30.
[9] See *Medicine Betrayed*, *The participation of doctors in human rights abuses*, BMA, 1992.
[10] *Gruskin and Tarantola (2000), p25.*
[11] A/60/348, para 8.

Moral foundations - In pursuing this question it might be helpful to distinguish between different types of conduct individual health professionals and national medical associations might pursue in relation to the right to health and MDGs before we analyse their potential role and responsibilities.

As we saw above, the right to health is a comprehensive right that encompasses both *freedoms*, i.e. rights *not to* be interfered with and *entitlements*, i.e. rights to be provided with some health intervention. Those different aspects also give rise to different types of correlative duties. Freedoms give rise to what is usually called negative duties, i.e. duties *not do things* that might affect the rights in question. Entitlements, conversely, give rise to duties *to do something* for the benefit of the right holder (positive duties). The same framework can be applied to MDGs, though perhaps not in the language of duties required by human rights standards. MDGs can be furthered by negative as well as positive action.

Health professionals can perform a *direct* and an *indirect* role in the promotion of the right to health in both negative and positive aspects. In the direct role, health professionals can refrain from violating the right to health, by for instance refraining from participating in acts of torture, experimentation without consent, physical punishments to prisoners etc. They can also directly provide health benefits to patients, such as free health advice and care. As to an indirect role, they can try and protect patients from being subjected to those harmful practices such as torture, by for instance denouncing cases of violations that come to their knowledge (whistle blowing).[12] As well put in a paper, "*[t]he skills of physicians, medical and forensic scientists, and other health workers are uniquely valuable in human rights investigations and documentation, producing evidence of abuse more credible and less vulnerable to challenge than traditional methods of case reporting."*[13] They can also speak out in favour of health interventions that are needed by particular groups of the population and pressurise government to allocate resources for those needs.

The question here is, which of those roles, if any, are health professionals under a duty, moral or legal, to perform, and to what extent can they be expected to discharge such a duty, if existent?

Just because someone is an essential instrument to the achievement of a certain desired goal or right does not mean they have a duty to act as such instruments. It is impossible to build houses without builders, but this does not necessarily mean that builders have a special responsibility to promote the right to housing recognised in international and national law in a similar way as the right to health. Does it follow that doctors and other health professionals also do not have any special responsibilities towards the right to health?

It would appear to be wrong to say that health professionals and their associations have no duty or role at all to play in the promotion of the right to health. The special relationship between health professionals and the right to health, their technical and political ability to do something, would seem to attract some responsibility to act.

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[12] As well observed in *The Medical Profession and Human Rights*, "Doctors can be confronted with human rights violations in various ways and they are often the first people to observe that abuses are occurring, simply by 'doing their job'. As a result, there is considerable potential for the profession actively to protect and respect human rights and medical ethics during the course of their work." At 500

[13] Geiger HJ, Cook-Deegan RM "The role of physicians in conflicts and humanitarian crises. Case studies from the field missions of Physicians for Human Rights, 1988 to 1993." *JAMA*. 1993 Aug 4;270(5):616-20

Moreover, it is in the central ethos of the health profession to alleviate suffering and to promote health. As expressed in the objectives of the World Medical Association when it was formed in 1946 and in many statutes of national medical associations around the world, one of the core objectives of the medical profession is *"to assist all peoples of the world to attain the highest possible level of health"*[14] The American Medical Association *Declaration of Professional Responsibility* contends that "*as members of the medical profession, physicians are entrusted with promoting not only the good health of their patients but also of society as a whole*."[15]

What the exact scope of this duty is, however, is a complex matter which we can only touch on in this paper.

Some duties are clear enough. Health professionals are very familiar with the so-called negative duties attached to their activity. Medical ethics codes have long established limits to the activities of health professionals in order to protect patients' interests such as autonomy, privacy, dignity and wellbeing. Some of those interests are now recognised as fundamental human rights. As a consequence, as well as their ethical duty to respect them doctors and health professionals also have a reason from human rights to do so. The conduct of research without the patients' consent, for instance, was deemed a grave violation of ethics by the Nuremberg Code of 1947 and was recognised as a breach of human rights tantamount to torture in the International Covent of Civil and Political Rights of 1966. Both torture and medical intervention without consent are regarded as infringements of the right to health according to General Comment 14 of 2000.

Nuremberg Code 1947

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.

UN International Covenant on Civil and Political Rights

Article 7 – No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Participation in torture has also been codified as a grave violation of medical ethics and human rights.

[14] T. C. Routley. "Aims and objects of the World Medical Association", *World Medical Association Bulletin, 1*, no 1 (1949): 18-19.
[15] Available at http://www.ama-assn.org/ama/pub/category/7491.html accessed on 23.6.2006.

Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Adopted by General Assembly resolution 37/194 of 18 December 1982

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 2
It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.

For the purposes of this paper, however, we must also ask if doctors also have a duty, individually or through their national medical associations, towards individuals of other countries, in particular developing ones. It is difficult to think of many situations in which doctors and health professionals of a developed country can directly interfere with negative aspects of the right to health of individuals in developing countries, unless they physically go there or directly treat patients from those countries, as may be the case if doctors work with aid or humanitarian relief organisations, or are engaged in testing pharmaceuticals in developing countries. Here the duty is straightforward enough: wherever the patient is, and wherever it comes from, the health professional has to respect his autonomy, dignity and wellbeing.

To take a slightly different question, do health professionals have any duties to patients in other countries and with whom they are not in direct relationship? That is, patients who are being subject to treatment or research without consent, or who are victims of torture or other inhuman treatment in other countries. Should this concern the doctor in developed countries? How can or should s/he act? Is the national medical association in a stronger position to do something?

Such a duty, or a role, would be *positive* in character, which presents other complex issues. We saw above that the right to health includes also what is called entitlements. In General Comment 14 this is interpreted as a right to "*a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health*." It is straightforward that health professionals should not engage in conduct that harms the health of individuals, such as torture, and should refrain from disrespecting the right of patients to control their own health and body. That demands negative conduct, i.e. omissions which, incidentally, apply to every individual, not just health professionals.[16] Less clear is whether health professionals have, and to what extent, a responsibility

[16] Health professionals might attract more blame when they engage in those actions given the opposite aim of their activities.

towards the availability of a system of health protection for the population as a whole. They are surely, as we saw, essential instruments in such a system. Without health professionals a health system can achieve very little. But what is the responsibility of individual health professionals, or collectively through their associations, in the availability of such a health system?

It seems clear that whilst the negative duties *not to torture* and *not to treat* without consent fall on individual health professionals the positive duty of providing an adequate health system cannot. It takes an organization to do so, and one with incredible amounts of resources. It is often agreed, thus, that this positive element of the right to health is primarily a duty of States.

Health professionals and health associations can of course contribute to this aim. But how, and to what extent?

If the public system is poorly resourced and pays badly, are health professionals under a duty, moral or legal, to stay in that system rather than look for positions in the better resourced and paid private sector, even knowing that doing so they will make the care received by poor patients even worse? Should private health providers attend poor patients without charging?

Those are thorny questions that fall outside the limited scope of this paper, but they are important ones that would deserve further future attention. For our purposes here it is important to notice that negative duties are often much less controversial than positive ones, and that this affects our topic because action towards the right to health and MDGs in developed and developing countries will mostly be of a positive character.

Whatever the positive duties of doctors and medical associations might be towards their own patients, a separate question is: *are they limited to the doctor's individual patient or do they extend to the community as well? If they extend to the community, is it the local, national or global community?*
When appraising an individual doctor's responsibilities one might be inclined to limit his or her responsibility primarily to the individual patient and, secondarily, to the local community. It might be too demanding to claim that the individual doctor should be involved in treating patients, looking after the health of the community and also doing something about the health problems of other peoples in other countries. When it comes to national medical associations, however, this might seem less implausible, especially for those NMAs in developed countries that have reasonable resources at their disposal. It could be argued, for instance, that health systems should not recruit from countries or localities where there is a shortage of healthcare providers, and that health professionals of the recipient system have a duty to combat this through their medical association.

The profession's own view – Special Responsibility

It is interesting to note, at this point, that by their own established aims national medical associations are not only entrusted with protecting the interests of its members. *Their remit is usually broader and includes, often as their main objective, the promotion of the medical science itself and its cores values, such as public health concerns and the availability of good health care for everyone, a value that is also at the core of the right to health.*

The BMA articles of association, for instance, establish as its main objective, as we saw above, *"to promote the medical and allied sciences, to maintain the honour and interests of the medical profession, and to promote the achievement of high quality health care."* The Brazilian Medical Association also states in its articles of association that one of its aims is *"to contribute to the elaboration of the national health plan and the improvement of the health system."*[17] The same is true of the Danish Medical Association, which states in its website that its main role is *"to serve as the body through which the influence of the medical profession may be exercised on general social issues in the best interest of health and the health care system."*[18]

Doctors and other health professionals' organizations see themselves as having special moral duties arising from their privileged position in society.

The British Medical Association, for instance, made the following statement in its seminal report on doctors' participations in human rights abuses:

> *"Medicine confers both privileges and obligations … All citizens have a moral duty to oppose illegal brutality but in resisting the proliferation of ill-treatment, more is expected of the medical practitioner. If the possibility of abuses of human rights comes to the attention of medical practitioners they have an ethical duty to take immediate action."*[19]

In the aftermath of September 11th the American Medical Association released a *Declaration of Professional Responsibility* where it contends that "*as members of the medical profession, physicians are entrusted with promoting not only the good health of their patients but also of society as a whole*."

It thus asks doctors to commit to *"...respect human life and the dignity of every individual; ...refrain from supporting or committing crimes against humanity and condemn all such acts; and [to] ...advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being."*

This same understanding is exposed by the American Public Health Association

> *"If our mission is to 'fulfil society's interest in assuring conditions in which people can be healthy' we must accept our social responsibility to ensure the rights of all people to health and social justice. Further, as public health professionals, we are in an ideal position to support and advance human rights tenets and to promote compliance with, prevent the violation of, and decry abuses of human rights.*[20]

This idea of special responsibilities towards promoting human rights attached to the nature of one's profession is not exclusive to the medical profession. The legal professions has a similar view, and associations that bring together doctors and lawyers such as Global Lawyers and Physicians for Human Rights have articulated this in strong terms:

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[17] Brazilian Medical Association articles of association, section 2, ii, available at http://www.amb.org.br/estatuto.php3, accessed on 14.5.2006.
[18] Available at http://www.laeger.dk/portal/page?_pageid=33,774315&_dad=portal&_schema=PORTAL accessed on 17.5.2006.
[19] *Medicine Betrayed*, *The participation of doctors in human rights abuses*, BMA, 1992, at 195.
[20] American Public Health Association http://www.apha.org/journal/editorials/May00/ed5may00.htm, accessed on 12.6.2006.

> *"Lawyers and physicians, by virtue of their privileged position and their commitment to life, health, social justice, and equality, have special obligations to all people."*[21]

At the international level, The World Medical Association, a body that congregates approximately 80 national medical associations of countries around the world, states as its purpose *"to serve humanity by endeavoring to achieve the highest international standards in Medical Education, Medical Science, Medical Art and Medical Ethics, and Health Care for all people in the world."*

It has a human rights unit and has released several authoritative policy statements on the issue. In its widely recognized Declaration of Geneva doctors take a vowel when they enter the profession whose first paragraph states: "I SOLEMNLY PLEDGE to consecrate my life to the service of humanity."

Some situations are so damaging to the core value of the medical profession that they elicit responses far beyond the borders in which they arise. The classic example is the atrocities committed by doctors during the Nazi regime in Germany that prompted the creation of the World Medical Association and gave rise to the Declaration of Helsinki, an internationally recognised code of ethics for the conduct of medical research.

Another transboundary issue that has received international attention and elicited the response of the medical profession as a whole is the involvement of doctors in acts of torture. Torture is, of course, a profound threat to the right to health. It is certainly the duty of the individual doctor not to torture, or to participate in torture, and individual doctors might also feel they can and should do something against the problem by, for instance, speaking out. Collectively through international and national medical associations doctors might be more able to exert an effective role. The international community of doctors has asserted its role through the Declaration of Tokyo, which states:

> "*7 The World Medical Association will support, and should encourage the international community, the National Medical Associations and fellow physicians to support, the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.*"[22]

Finally, there might be an enlightened self-interest motivation to help. Some health problems have become global health hazards, and their solution, as a consequence, so-called global health goods (e.g. Avian Flu, Tuberculosis, and Infectious Diseases). The medical profession in a developed country might have an interest, thus, in combating these global health hazards in developing countries not only for humanitarian and justice reasons, but also for the protection of their own people.

It can be concluded that the health profession often sees itself as bearing special responsibilities to respect and protect the right to health and other health related human rights, not only within their own communities and borders, but also in other countries. This responsibility, moreover, has been translated into action in many different ways, sometimes with the involvement of national medical associations.

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[21] Global Lawyers and Physicians for Human Rights, http://www.glphr.org/mission.htm, accessed on 17.6.2006.
[22] Declaration of Tokyo, available at http://www.wma.net/e/policy/c18.htm , accessed on 22.6.2006.

In the next section we turn to some of the examples of good practice we found that highlight how the health profession, in particular through NMAs, can perform their role.

II
What can National Medical Associations actually do?

Having a moral reason to try and do something is clearly not enough to impose a moral duty to actually do it. Sometimes it is practically impossible for someone to act in the way morality would in principle direct and thus a moral duty will not arise. "Ought implies can".

As we have already mentioned above, some NMAs, such as the BMA and others in developed countries, are well resourced and have thus the capacity to perform the role highlighted above to a great extent. Many NMAs, however, are not in the same situation and cannot therefore be held accountable to discharge a strong role in health related human rights protection and promotion.

As put by one expert we have consulted in our research:

> *"National medical associations have a fundamental problem in working in this sort of area and this is the rapid turnover of their leadership. While the President of the BMA is in office for only a year, he is largely a figurehead, while the President of a national medical association in a developing country actually runs his/her organization and where terms of office are only one or two years, they each 'start from scratch' in their activities. At the same time these associations often do not have the resources to have on-going committees or the expertise in the issues ..."*[23]

Another important obstacle that needs to be reckoned with is the risk faced by many NMAs in carrying out the role of promoting human rights. In the BMA conference "Improving Health in the Developing World: what can National Medical Associations do?" held in June 2006, many representatives of developing countries' NMAs expressed, under the protection of the Chatham House rule, that they face serious threats from their government not to raise any issues related to human rights. Sometimes the threat is done through political pressure, given in many countries the NMA's own existence and functioning is heavily dependant on the government. We have heard one account of an NMA being threatened with closure if they started to work with any human rights issues. In other occasions, NMA representatives risk their own physical integrity if they dare working with human rights and criticise government.[24]

It must be borne in mind, thus, that the potential role of NMAs varies greatly according to their economic capacity and the political situation of their countries. Here is where partnerships between NMAs in developed and developing countries could be a way ahead (see section below). Even those, however, might be insufficient to circumvent those obstacles, and have to be very sensitive to the risks involved. The potential work we will discuss below has to be seen therefore as a generic guide to be adapted according to the circumstances of the place in question.

[23] Maryanne Halesgrave, email interview, 22.5.2006.
[24] This problem has been expressed at least by two developing world NMAs' representatives in the June conference.

Potential work

There are different ways in which health professionals can act, individually and collectively, to promote the right to health and MDGs.

In the seminal book *The Medical Profession and Human Rights: handbook for a changing agenda* (2001)[25], the BMA set out the following areas in which it believes NMAs have responsibility concerning human rights:

- Providing leadership;
- Providing guidance and promoting awareness;
- Establishing a human rights committee;
- Supporting the rehabilitation of survivors;
- Supporting doctors with dual responsibilities and whistleblowers;
- Bringing disciplinary action against complicit doctors;
- Campaigning against harmful practices;
- Campaigning for equitable access to quality health care;
- Promoting measures to improve health and welfare.

In another important report on the role of health professionals in human rights issues, the non-governmental organisation *Physicians for Human Rights* has highlighted the health professionals often find themselves *"in an environment of state demands or threats"*. It is here that collective action, which can be performed by NMAs and other organisations, proves important.[26] The report stresses the following five areas of action, some overlapping with the BMA's report above quoted:

"7.1. Support for individual health professionals who are subjected to reprisals, threats, or demands by the state for subordinating patient human rights to state interests, through every means possible, including speaking out publicly.

7.2. Advocacy to change laws and regulations that prevent or impede health professionals from meeting their human rights obligations to patients.

7.3. Proactive steps to prevent health professionals from being placed in positions where they will be at risk of participating in a violation of a patient's human rights.

7.4. Advocacy to end state policies and practices that prevent health professionals from providing health care to some or all patients in need, including communities of patients, consistent with professional standards of care. These practices include, among others, a state's failure to take adequate steps needed toward the attainment of the highest standard of health for all, inequity in allocation of health resources or benefits, and discrimination (or tolerance of

[25] At 503 ff.

[26] This same point has been made by the International Council of Nurses as early as 1983, in their statement The Nurse's Role in Safeguarding Human Rights, where it is observed that "nurses have individual responsibility but they can often be more effective if they approach human rights issues as a group." Quoted in *Caring for Human Rights, Challenges and opportunities for nurses and midwives*, Amnesty International, 15 June 2006, at 84.

discrimination) against women, refugees and immigrants and ethnic, racial or religious groups or on the basis of disease or disability.

7.5. Advocacy for policies to promote, protect and fulfil human rights that avoid dual loyalty conflicts, such as Patient Rights Charters, workplace occupational health policies and Public Service standards."[27]

The same issue has been entertained in Judith Asher's *The Right to Health: a resource manual for NGOs*[28]. She puts forward three examples of activities that national medical and other health professional associations can carry out concerning the right to health:

- Reviewing existing relevant legislation, policies and practices;
- Promoting and monitoring the right to health; and
- Participating in the treaty monitoring process.

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As the studies quoted above confirm, NMAs can realistically exert more of an *indirect* role in the promotion of human rights in general and the right to health and MDGs in particular. The most prominent examples of activities mentioned in those studies fall within the sphere of *advocacy* and *awareness raising*. A more direct role is to be found in the *support of individual doctors* who themselves try and promote human rights, be it by denouncing human rights abuses or by actively delivering health goods to needy populations. But a *direct* role, though certainly less frequent, is not to be discarded, especially by those NMAs with significant resources at their disposal, or with political clout to find those resources with funding agencies.

We will now see a few initiatives that fit in some of these areas and seem to be interesting examples of good practice for NMAs. Before that, however, it is important to reemphasise a point already made that *"few such associations in developing countries will have the resources to carry out all of the above activities without the aid of outside organizations."*[29] Here, it bears repeating, is where partnerships between NMAs in developed and developing countries seem to be desirable, as has actually been put forward by the BMA in the already mentioned report.[30] It is also important that NMAs, in developed and developing countries alike work together with NGOs and other medical organisations. Such networking can leverage the potential effectiveness of the work of NMAs.[31]

i. General awareness raising

A clear potential area in which NMAs can exert a significant impact is that of raising awareness of the right to health and the MDGs among doctors and society as a whole. In this field, the BMA is duly regarded as a leading NMA. We have already mentioned its reports on torture, the participation of health professionals in human rights abuses and the handbook on health professionals and human rights among many other activities

[27] The report, *Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms* (2003) is available at the Physicians for Human Rights website, http://www.phrusa.org/healthrights/dual_loyalty.html , ,)
[28] Published by the Commonwealth Medical trust in August 2004, at 151.
[29] Id.
[30] *The Medical Profession and Human rights*, at 499.
[31] This same point has been made by Judith Asher, *op. cit.*, at 151, and by Jim Welsh from Amnesty International, interview on the 7.6.2006 and email correspondence on the 8.6.2006.

promoted by the BMA to raise awareness of human rights issues concerning the medical profession.[32]

But we want to emphasise here the importance of *educating* health professionals in human rights issues in general and the right to health in particular, an area in which NMAs can play an important role but, so far as we have seen, are still rather timid.

The UN Special Rapporteur on the right to the highest attainable standard of health has noted in one of his reports how lack of awareness of human rights and the right to health among health professionals is one of the complex factors that might lead to inadequate compliance by those professionals.[33] As he noted, *"human rights education is an essential starting point for equipping health professionals with the knowledge and tools to empower them to promote and protect human rights."* He called thus NMAs to *"raise awareness about human rights and stimulate demand for human rights education among their members"*.[34]

The World Medical Association has passed a resolution on this topic, [35]and, in the specific case of torture, it is also an obligation under international human rights law that governments provide health professionals with education on torture and its human rights implications.[36]

It seems to us that NMAs could perform a more active role in health professionals' education in human rights. The joint initiative of the Norwegian Medical Association and the World Medical Association is a good example of how this might be done. (see box 1) This free web based course on human rights to prison doctors should be more widely publicised and could be replicated in other areas. A web based course on the right to health care and MDGs for doctors, for instance, could be sponsored by developed countries NMAs. The BMA handbook on health professionals and human rights is another important educational tool that could be made more widely available to NMAs in developing countries, perhaps by translating it into other languages and making its content free in the BMA website in a similar vein as the Norwegian Medical Association course mentioned above, or the materials on Access to health care for asylum seekers http://www.bma.org.uk/ap.nsf/Content/asylumhealthcare developed by the BMA itself.

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[32] For information on the BMAs activities on human rights see its website, http://www.bma.org.uk/ap.nsf/content/home in particular the links ethics, human rights and international activities.

[33] Apart from training in human rights interdisciplinary work in this field is also important. Some health professionals are experts in public health interventions whose aim is the improvement of the health conditions of the population as a whole and therefore significantly overlap with the right to health. Public health policies, however, can inadvertently violate right to health by for instance discriminating some groups or neglecting their needs. A health policy that might seem efficient from a public health perspective because it reduces significantly the burden of a certain disease might nevertheless be contrary to the right to health in that if neglects a part of the population that suffers from that disease. See, for instance, Health Inequalities: Concepts, frameworks and policy, Briefing Paper, NHS, Health Developing Agency 2004, stating that only recently the public health aim in the UK changed from simply "health gain" to "health equity". See also, on the need for human rights training and interdisciplinary efforts Gruskin and Tarantola (2000), p30.

[34] A/60/348, paras 8 ff.

[35] World Medical Association Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide, Adopted by the 51st World Medical Assembly Tel Aviv, Israel, October 1999.

[36] See article 10 of the UN Convention against Torture, which states that "Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment."

Box 1 - Norwegian Medical Association "Doctors working in prisons: human rights and ethical dilemmas" - A web-based course for health care personnel working in prison (2004)

The Norwegian Medical Association, in cooperation with World Medical Association, has developed a web-based course on human rights and ethics for prison doctors. Various associations and organisations have also contributed to the course, including the BMA and Amnesty International. The project was sponsored by the Norwegian Ministry of Foreign Affairs. The course can be accessed and followed free of charge from any computer around the world at http://lupin-nma.net/.

ii. Advocacy

International human rights law imposes a duty on developed governments not only to realise the right to health in their own countries but also to assist and cooperate with developing ones in the realisation of this right (we called this the duty of IAC-H).[37][add footnote to other paper]

NMAs in developed countries are in a strategic position to cooperate with and put pressure on their own governments so that they comply with their duties in the field of health, i.e. in the realisation of the right to health. We have seen that those national and international duties have three different dimensions: *respect, protection and fulfilment*. The first demands non-interference at home and in other countries' with individuals' capacity to realise the right to health. The second imposes measures to protect individuals at home and in other countries from interference by third parties in their ability to enjoy the right to health. The third implies positive action, that is, actual help for individuals at home and in other countries so that they can realise the right to health.

NMAs can work with their governments in all three dimensions. Advocacy in favour of an equitable health system at home is an important task to be discharged by NMAs. Even in developed countries, as it is known, many individuals lack access to health care or suffer discrimination in health care services. Some NMAs have been active in this field (see Box 2), but more could be done, particularly in those countries where private health services are a significant component of the health system.

Box 2 – The American Medical Association's seems to do interesting work in this field. According to its website, it has made expanding coverage and increasing access to care for the 45 million uninsured Americans one of its major advocacy priorities. Its Reach Initiative **Reaching Equitable Access to Care for Health** is designed to strengthen the medical safety net system, especially free clinics by promoting physician volunteerism, supporting clinics in local communities, and fostering an ethic of service among the next generation of physicians. http://www.ama-assn.org/ama/pub/category/10376.html

The Canadian Medical Association has also done interesting work in this area. An interest example was its involvement, as an intervener, in the court case Chaoulli

[37] See Ferraz and Mesquita (2006), *supra* note 1.

and Zeliotis v. Quebec, in which a Quebec law forbidding private insurance to be used to cover treatment provided under the public Medicare system was challenged. The CMA urged the court to recognize that "failures in that system may represent a breach of the Canadian Charter of Rights and Freedoms. http://www.cma.ca/index.cfm?ci_id=4516&la_id=1

In the international front, it has become increasingly clear that policies pursued by developed countries individually or collectively through international organizations can affect the right to health in developing countries. The topical issue of health professionals' recruitment in developing countries to solve the shortage in developed countries is a clear example, and one in which NMAs can play an active role, and have actually done so to some extent in the past.

The BMA itself has been active on this issue, working with the UK Department for International Development, supporting research on the topic and organising conferences which helped to raise the profile of the problem. In 2005, with the participation of other NMAs, it released a call to action urging the following four points:

1. All countries must strive to attain self-sufficiency in their healthcare workforce without generating adverse consequences for other countries;
2. Developed countries must assist developing countries to expand their capacity to train and retain physicians and nurses, to enable them to become self-sufficient;
3. All countries must ensure that their healthcare workers are educated, funded and supported to meet the healthcare needs of their populations;
4. Action to combat the skills drain in this area must balance the right to health - of populations and other individual human rights.[38]

This initiative is to be commended and the work of the BMA in this field is an example that can be followed by other developed NMAs, especially from those countries which benefit most from the skills drain. But perhaps more on this issue could be done to complement, not replace, this work, as we will suggest in the next sections.

NMAs can also be more active in advocacy before the UN, monitoring compliance of their countries with human rights standards and participating in initiatives such as shadow reports to the Committee on Economic, Social and Cultural Rights. They should also put pressure on their governments to comply with their pledges to give aid to the developing world, as the BMA has recently done in its joint *Letter from leading non-governmental bodies to Tony Blair urging him to fulfil his 2005 promises from the G8 summit.*[39]

[38] See The Health Care Skills Drain – A call to action, May 2005, at http://www.bma.org.uk/ap.nsf/Content/skillsdrain

[39] Available at http://www.bma.org.uk/ap.nsf/content/home, accessed on 22.7.2006.

iii. Support of individual doctors

NMAs could also perform another facilitating role which must not be overlooked. Many doctors would want to go on such missions but are hindered by issues such as leave allowances, job security, etc. In the foreword of the toolkit *International and Humanitarian Health Work*, it is recognised that *"the degree to which NHS staff are able to participate depends on a range of factors, including the ability of their employer to release them."*[40]

NMAs in developed countries should be prime advocates for the facilitation of humanitarian and human rights work by their health professionals. The German Medical Association seems to have done interesting work in this field (see box 2). In the UK, many health professionals carry out international work, often through initiatives such as NHS links, which is certainly to be commended. Those initiatives, however, are scattered and heavily dependent on the interest and enthusiasm of the management team of the particular NHS institution. Many willing health professionals still find it hard, as a consequence, to carry out international work for lack of leave and management support. The BMA could exert an important role in advocating the mainstreaming of those initiatives.

Box 3 - German Medical Association - Bundesärztekammer (BÄK) states in its website under the heading of Humanitarian Aid (Humanitare Hilfe) that it advocates with employers and government that doctors who wish to do humanitarian work abroad should have special leave and their jobs safeguarded. It has also advocated for unemployed doctors who wish to carry out humanitarian volunteer work abroad do not lose entitlement to income/unemployment support. It managed through its advocacy to establish an agreement with the authorities so that unemployed doctors doing humanitarian work for a period of up to 6 weeks would not lose that entitlement.[41]

iv. Direct action and *partnerships*

Health professionals can take direct action, such as helping people in developing countries in need of health interventions. There are many well-known initiatives of this kind. Organisations such as Medecins Sans Frontieres provide an important service through sending doctors from around the world to developing countries with acute needs. Less well known is the initiative of the Ethiopian North American Health Professionals Association (ENAHPA) (see box 4). We have not found any direct involvement of NMAs in such initiatives, though the partnership between the Norwegian and Zambian Nurses Association show that this is a possibility (see below, Box 6).

NMAs in developed countries could be involved in those initiatives in several ways, from simply offering meeting space to becoming involved more actively and encouraging those projects. Many of the professionals who migrated to developed countries are

[40] Department of Health, July 2003, available at http://www.dh.gov.uk/assetRoot/04/07/45/76/04074576.pdf , accessed on 20.7.2006.

[41] We have tried to raise more information with the German Medical Association about these and other initiatives concerning human rights but had no success. We cannot be sure thus of the effectiveness of these initiatives, but they seem to be in the right direction, especially under the area of *support to individual* doctors highlighted above as a prime potential area work for NMAs.

probably members of its NMA. NMAs should encourage and support those doctors to come together to discuss the skills drain issue and other health problems in their country and set up initiatives to tackle them.

Box 4 - The Ethiopian North American Health Professionals Association (ENAHPA)

ENAHPA is a non-profit organization established in November 1999 in Detroit, Michigan, by Ethiopian-born medical and non-medical professionals. Volunteers embark on missions to Ethiopia twice a year, giving their time to addressing the country's healthcare crisis. In their webpage, ENAHPA states its mission as: Provide medical and surgical services with special focus on women and children; Promote preventive health maintenance; Deliver educational materials and medical supplies to healthcare facilities; Transfer skills and state-of-the-art technologies to healthcare professionals and trainees; Provide free advanced training to Ethiopian doctors and medical students; Provide free anti-retroviral treatment for HIV/AIDS victims; Generate financial and educational support for children orphaned by AIDS; Improve maternal and child healthcare. ENAHPA carries out missions to Ethiopia with teams of doctors to perform operations and train Ethiopian health professionals. Even though cardiovascular disease is the fourth cause for hospital admission and a major cause of morbidity and mortality, there is no centre for comprehensive cardiovascular care. Until 2003, no open-heart surgery had been performed in Ethiopia. The Enhapa team was the first to do so and, since then, they have carried out another 4 missions. The goal is to establish a comprehensive centre. In the Spring 2005 mission, in 9 working days its team performed 93 surgeries, including cardiac, neurological, videolaparoscopic and pacemaker implant procedures. It also trained 250 health professionals to enable them to carry out the procedures by themselves. Human resources – 500.000 Ethiopians have left the country in the 80s, many of them health professionals. The health system suffers from a lack of human resources. ENAHPA has teamed up with the Ministry of Health to help tackle the problem. Diaspora professionals teach people in Ethiopia through videoconference in the distance learning project. The aim is to train a group of professionals in Ethiopia who can then train others. Together with the John Hopkins University Division of Infectious Diseases they have certified a core group of 21 health care workers in HIV medicine for instance. There is also the aim to establish fellowship programmes in American and Canadian universities for Ethiopian professionals. ENAHPA has also a project for donation of books and equipment (32.000 books have been donated so far) and a project to support orphan children whose parents died of AIDS (40 sponsored).

This kind of initiative would be particularly valuable because having the involvement of nationals of the targeted country would bring a better understanding of the problem and less resistance from the local community, including the local NMA and local health professionals.[42]

[42] This sense that local health professionals might be wary of initiatives set up in developed countries NMAs to help them has been confirmed during our research by various stakeholders interviewed.

It is important to notice that missions to developing countries of the sort mentioned above are not simply one off projects that help locals for a limited period of time and have no lasting and significant impact in the local situation. All those missions should ideally have a strong capacity building component. Just as importantly, however, it provides those involved with a better insight of the situation, which can then be fed back and used in the NMA policy setting and campaigning activity.

Apart from being the focal point for these initiatives to germinate, NMAs could of course give direct financial support for them or help to secure such support. In the UK, the BMA has been involved together with the Department for Health and the Royal College of Nursing in the Humanitarian Fund, which covers incidental expenses of teams undertaking humanitarian projects. This limited funding could be extended and, together with more favourable leave arrangements (see iii. *Support of individual doctors* above) could promote better this important type of initiative.

Donation of equipment - Another simple but important activity is the donation of equipment. The initiative by Enhapa highlighted in box 4 above includes, as we saw, the donation of all the equipment necessary to carry out their missions. Another simple but effective donation programme is that of The American Medical Association which facilitates donation of stethoscopes by its members to poor countries (see Box 5 below).

Box 5 – American Medical Association WorldScopes

WorldScopes collects stethoscopes from US physicians and distributes them, with the help of humanitarian organizations, to communities around the world where medical supplies are scarce. http://www.ama-assn.org/ama/pub/category/12768.html

Partnerships

Given the lack of resources of many NMAs in developing countries, many of the initiatives above could be pursued only in collaboration with NMAs in developed countries. NMAs in developing countries are better placed to identify areas of potential work but might lack the resources to act. The idea of partnerships, or twinning of NMAs has for long been proposed by the British Medical Association. In The Medical Profession and Human Rights it stated that *"The BMA supports the concept of exchanges and partnerships between well-developed and well-resourced organizations and partners in less developed situations with fewer resources".*[43]

As far as our research could find out, however, not much progress has been made in that direction within the medical profession.[44] Nurses seem to be taking the lead in this area (see box 4), and their example might well be followed by NMAs.

It is important however to note some difficulties that might arise. On the side of developed countries NMAs, there might be resistance from their membership for financial support. On the side of developing countries NMAs, they might sense that developed countries offer to help is paternalistic. It seems important here that, as in

[43] *Op. cit.*, at 499

[44] We did find examples of partnerships between more restricted medical organizations such as the Royal Colleges but not between NMAs as such.

development assistance and cooperation in general, the value of *ownership* (that is, that policies be devised by the developing countries themselves) is pursued. If NMAs or their members from developed countries become involved in health projects in developing countries, they should endeavor to respond to development/health priorities in developing countries themselves.[45] The difficulties would arise if the local priorities are clearly not responsive to those people most in need. In that case developed countries' NMAs should perhaps not get directly involved in projects but engage in dialogue to discuss a change of priorities.

Political instability and discontinuity in the leadership of developed and developing countries NMAs may also be an obstacle for cooperation. Here the establishment of permanent human rights committees could be a way forward.

Box 6 - International Nursing Partnership Project
http://www.icn.ch/partnership.htm

The International Council for Nurses has an International Nursing Partnership Project aimed at documenting on-going and new international partnerships "as a tool to encourage similar initiatives and aid in planning new ventures fostering partnerships between two or more countries national nurses' associations, universities, health facilities, regional and international organisations, NGOs, and others."
The partnerships listed in the database are not restricted to human rights, MDGs or right to health issues, but some are closely related to it. Of note is for instance the partnership between the Norwegian Nurses Association and the Zambian Nurses Association entitled "HIV/AIDS among Nurses and Midwives in Zambia". The objective of the project is to contribute to reducing the spread of HIV among Zambian nurses and midwives, support hose already infected, establish a support network among nurses in Zambia, build capacity in the health system to deal with working environment infection, train nurses on HIV/AIDS management. The project involves various measures to achieve these goals, including 5 day training sessions for 3000 nurses and midwives over a five year period and is funded by NORAD (The Norwegian Agency for Development Cooperation) and the Norwegian Nurses Association, on a ration of 90/10%. The estimated average annual costs are US$ 380.000.

There seems to be no reason why such partnerships cannot be established between national medical associations as well. In the BMA Conference "Improving health in the developing world: what can national medical associations do?", several representatives of developing countries NMAs expressed their welcome to the idea of partnerships. [justify text in this para to make formatting consistent]

Partnerships can, and perhaps should, involve other actors as well beyond NMAs. Some NGOs have more expertise than NMAs in working with human rights and could add

[45] In the development terminology, this is often called *alignment*, i.e. donor should align their assistance with the policies devised in the recipient country See, for a comprehensive view of these issues, **HARMONISATION, ALIGNMENT, RESULTS: REPORT ON PROGRESS, CHALLENGES AND OPPORTUNITIES, Joint Progress Toward Enhanced Aid Effectiveness High Level Forum, Paris, March 2005.**

great value to the work of NMAs. [46] Partnerships with organizations that are better able to raise funds can be also important. Even well resourced NMAs are not always able to command resources at the scale needed to make any impact. Resources can of course be pursued directly by the NMA from, for instance, their own government's development agency or department (we saw that NORAD funded two of the initiatives we highlighted above, boxes 1 and 4). Other non-governmental organisations, however, can also prove effective partners of NMAs in conducting human rights work that demands significant funding. The project of the South African Medical Association to equip GPs to treat HIV is a good example (see Box 5).

Box 7 - Tshepang Trust HIV/AIDS Treatment Programme

The Tshepang Trust (also known as Tshepang), is an HIV and AIDS Comprehensive Programme of the South African Medical Association (SAMA) supported by the Nelson Mandela Foundation (NMF). SAMA, whose mission is to empower doctors to bring health to the nation, is a professional association and a representative body of 70% of all doctors registered with the Health Professions Council of South Africa. The Tshepang Trust aim is to ensure that every General Practitioner (GP)'s rooms becomes equipped to treat, care and support HIV and AIDS patients and also to become a conduit for destigmatisation, prevention and combating the spread of the disease. www.tshepangtrust.co.za

Conclusion

Our research has shown that the medical professions have not abdicated, in principle, from their responsibilities regarding the promotion and protection of health related human rights in general and the right to health in particular. On the contrary, most professional medical organizations see their occupation as bearing a special responsibility arising out of the privileged position they hold.

Systematic and visible work on human rights by National Medical Associations is, however, rare. This is reflected not only in the small number of initiatives we managed to find,[47] but also in the fact that, out of the 7 examples of good practice we included in the paper two do not have the involvement of NMAs.

Those few initiatives we have highlighted are however encouraging and show that, with some commitment and creativity, NMAs can exert an important role, even within the limited resources they can dispose of.

Partnerships between NMAs themselves and between NMAs and other actors seem to be the most effective way to leverage NMAs capacity to affect an impact in the promotion of the right to health and health related MDGs. This is a field of inquiry which we were able to only touch upon in this paper but that certainly deserves further attention and research in the future.

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[47] We have already noted that our research was limited in scope and resources, so we cannot be completely sure that some good examples of good practice have not been left out. We can be confident, through, that this probability is very low, since we have consulted with well informed experts in the field whose conclusions were similar to ours.

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